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ABSTRACT

Responsive Therapy is an integrative model that purports to structure the use of a variety of intervention models, each in its own theory-pure context. It is firmly based in phenomenology. Beginning with a phase that relies on critical, universal therapy skills, therapy proceeds through a highly active, hopefully collaborative, intervention phase. While not unique to Responsive Therapy, it espouses avoidance of the Diagnostic Statistical Manual of Mental Disorders-III. Eclectic counseling is the practice of drawing a mixture of techniques from any theoretical persuasions and combining them in unique, creative, or comfortable ways. An eclectic approach is not integrated by theory. The increasing demand for accountability coupled by a questionable priority for doing labels over doing therapy has re-established the preference for the medical model of counseling. The new dilemma contrasts sensitivity to client reality (phenomenological) with accountability of therapeutic interventions (neo-clinical). Responsive Therapy prescribes the following: (1) remove diagnosis from therapy; (2) accomplish initiation, ventilation, and clarification through reliance on universal counseling skills and explore client phenomenal reality in order to identify client circumstances and style; (3) describe client circumstances and styles according to the client's cognitive, affective, and behavioral characteristics; and (4) select active intervention derived from understanding the client style and circumstance. Responsive Therapy provides a philosophy and a structure for enhancing professional accountability. (ABL)

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RESPONSIVE THERAPY: A BETTER FRAME THAN ECLECTIC

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Responsive Therapy: A Better Frame Than Eclectic

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What follows is primarily a position paper that addresses some major misdirections in the counseling profession. It is a trite statement to declare that one is not likely to arrive where he or she wishes to unless a direction is chosen. It is no less true that specifying a goal is useless if its articulation is followed by procedures that lead in mutually exclusive directions. For at least two generations, counseling has professed an identity with the client; the client is important, knowledgeable, and capable of movement from self-defeating to self-enhancing actions. No longer is that apparent in training nor in practice. The profession appears to have moved full circle from reliance on a medical model -- assess, diagnose, prescribe, treat -- to a fulfillment model of establishing a facilitative environment in which the client engineers his or her own change, and back to the medical model. The strengths and weaknesses of the medical model remain much as they were in the 1930's; the strengths and weaknesses of the fulfillment model continue, unchanged. It makes no sense at all for the profession to merely cycle between the two when a superior option is available.

A position paper may well begin with some assertions -- statements that establish a point of departure or a bias. Unlike formal logic, these are not givens to be accepted; they are postulations to be supported. Some pertinent assertions are:

1. TO BE ECLECTIC IS TO BE IRRESPONSIBLE.
2. DIAGNOSIS IS NOT A PART OF THERAPY.
3. THE DSM III IS A DANGEROUS DIVERSION.
4. TECHNIQUE FOLLOWS UNDERSTANDING.
5. RESPONSIVE THERAPY IS A SUPERIOR APPROACH.

What is Responsive Therapy? It is an integrative model that purports to structure the use of a variety of intervention models, each in its own theory-pure context. It is firmly based in phenomenology. Beginning with a phase that relies on critical, universal therapy skills, therapy proceeds through a highly active, hopefully collaborative, intervention phase. While not unique to Responsive Therapy, it espouses avoidance of the DSM III trap. The underlying theory, universal skills, and a frame for identification of client style and circumstance, as well as a nomenclature for categorizing extant therapeutic models are presented in Gerber, S. (1986) Responsive therapy: a systematic approach to counseling skills. New York: Human Sciences Press.

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What is Eclecticism and why are its practioners irresponsible? The Reader's Digest Great Encyclopedic Dictionary defines eclectic as: "Composed of elements selected from diverse sources -- One favoring no particular belief or practice, as in philosophy or art, but selecting from all schools or methods." In counseling, it can be seen as the practice of drawing a mixture of techniques from any/all theoretical persuasions and combining them in unique, creative, or comfortable ways. The rationale for labelling such a practice as irresponsible is that, by its very nature, an eclectic approach is not integrated by theory. It is technique rich, theory poor. A Gestalt principle says that meaning comes from the context; an extension of this principle suggests that the power of an intervention technique comes from the theoretical context in which it is embedded. To take the technique out of context is to weaken or disable it. In practice, the most frequent manifestation of irresponsibility is in the following up of a potentially effective technique with another which counters the first. Examples include verbal encouragement or even statements of disappointment when a client fails to achieve a reinforcer in a contingency management program or when progress is being made with a

cognitive therapy confrontation only to be destoyed by the direction to descend back into the depression in response to, "Tell me what you are feeling now."

Some personal professional history will serve to elucidate the issue and set the foundation for the earlier description of the profession coming full circle. For the graduate student in the fifties, the therapeutic training mileu had three prongs. Williamson's Directive Therapy was firmly established and was, perhaps, the traditional approach. It was basically the medical model applied to counseling. The therapist is wise and knowing; clients need direction to overcome their problems; the process is assess -- diagnose -- prescribe/treat. Rogers presented a different frame for interpreting the client and the dynamics of therapy. Given a facilitative emotional environment -- genuine, non-judgmental, non-restrictive -- clients would martial their own resources in their own behalf and "cure" themselves. A third option was available for therapists who couldn't/wouldn't conform to either of the other two choices: Thorne's Eclectic Therapy. In reality, my training program was somewhat schizoid in its emphasis on non-directive techniques and theory base while requiring considerable facility in psychometric skills. In essence, the message was to be eclectic, yet one particularly strong-spoken, and apparently influential faculty member, said, "Do not be eclectic! It's theory-weak! Be a disciple and learn well your chosen way."

The dilemma for me and for other students of therapy was that we were being trained in a mixed model, taught to call ourselves Rogerian and to avoid eclecticism, and turned loose on a practical world that provided even less consistent expectations. There were many "closet eclectics" at that time. When there are major deficiencies in the two major approaches and an even larger weakness in the eclectic alternative, there is a high degree of cognitive dissonance. The resolution to the dilemma of avoiding eclecticism because it is ineffectual and avoiding restriction to any one discipleship because it is unnecessarily limited is to adopt an integrational model, Responsive Therapy, one that structures the use of many intervention models, each in a theory-pure context.

Appearances suggest a similar condition today to that of the fifties, but with the poles reversed. The increasing expectation/demand for accountability coupled by a questionable priority for doing labels over doing therapy has re-established the preference for the medical model. It is no longer permissable to be non-directive; such does not establish the therapist as accountable. Of course the major theoretical and philosophical base of the traditional client-centered approach is to leave the accountability to the client; the counselor's function is to create the environment that supports change.

There appears to be a clinging to the relationship principles and the "active listening" techniques of the recent professional past while, at the same time, a premium is placed on intake assessment and DSM III contortions. If the objective is to gather "objective" data in order to select the most appropriate diagnostic category in order to assign the related therapeutic answer, why spend time in mapping the client's phenomenal space? The two activities are philosophically opposed. A further manifestation of the new schiziod nature of counseling is the maxim to "Make your client a partner in the therapeutic process." If diagnosis truly is a professional function based on assessment and decision, then use of psychometric devices and lengthy intake forms that cover all of the possibilities (the traditional clinical approach) is the only defensible position. This is underscored by the nature of a litigious society which necessitates "CYA" tactics. There is no need to invest hours in finding what the client thinks, feels, or believes; to do so works against another pressure, that of the third-party payor that frames therapy in ten session episodes.

The new dilemma contrasts sensitivity to client reality (phenomenological) with accountability of therapeutic interventions (neo-clinical). For therapists who are unwilling to give up their client-centered roots, yet are required to meet externally imposed demands of agency funding, medical insurance plans, and health maintenance organizations, their approach becomes ineffectually eclectic.

Escape from this recurrent dilemma may be made by subscription to an integrative approach. It is possible to separate aspects or sequences of the counseling process and treat each in a logical, theory-pure, and effective way. Frequently the strategy for solution of client problems is to separate out or isolate one problem from others which obscure its identity and resolution. Similarly, separation of therapy into interdependent units may provide simplicity and elegance of management. Responsive Therapy prescribes the following subdivision:

1. Remove diagnosis from therapy. Diagnosis can be framed honestly as a management technique, useful in codifying clients for relative ease in computer accounting, research groupings, insurance reimbursement, and esoteric case staffings. Diagnostic labels are not particularly useful as indicators of intervention strategies. Each client must be approached in sensitive and often unique ways; therefore, the imposition of a label between assessment and intervention can only introduce a degree of insensitivity and error in the therapeutic process. Once we accept diagnosis as a product of therapy, not a facet or integral dynamic, then we can perform it more efficiently. Clients will be served better by a policy of "least restrictive labels" thus reducing the potential damage of pjorative labels.

2. Accomplish initiation, ventilation, and clarification through reliance on universal counseling skills; explore client phenomenal reality in order ot identify client circumstance and style. The Sequential Initiating, Tracking, and Enhancing (SITE) skills of Responsive Therapy are a compilation of commonly used techniques for accessing client experience. They include Indirect Lead, Paraphrase of Content, Summary of Content, Traffic Signs, Structure of Content, Paraphrase of Message, Reflection of Feeling, Formalization of Non-verbal Cues, Description of Situation, Summary of Messages, Silence, Touch, Pacing, Minimizing of Interrogation, and Process Control. This phase requires typically two or three sessions and results in:

3. Describe client circumstance and style according to their cognitive, affective, and behavioral characteristics. Circumstances or "problems" can be described according to their surplus (too much or incorrect) or deficit (absence or deficiency) nature. Surplus cognitions are the presence of beliefs that are inaccurate hence self-defeating; such are readily amenable to cognitive restructuring. Deficit cognition is ignorance of useful or necessary information; information exchange, teaching, or bibliotherapy are indicated. Surplus affect includes, for example, pent-up emotions or lack of training in recognizing and expressing emotional states; ventilative and expressive interventions are useful. Affective deficit results from long-term lack of personal validation; relationship therapies are most appropriate and most efficient for this state. Behavioral surplus is the presence of self-defeating habits; behavioral deficit is the absence of self-enhancing habits; operant techniques for the decrease, extinction, installation, or increase of situationally cued responses are especially useful here. Parenthetically, length of therapy will be a function of the type of intervention and not dictated by payment organizations.

Clients tend to approach their conditions with preferences that may be classed in the same dynamic categories. Some tend to be deliberative and contemplative (cognitive). Some are intuitive (affective). Some are reactive

(behavioral). Knowing client style makes it possible to (a) appeal to that style in seeking resolution, (b) confound that style if it is obtrusive, or (c) teach another style which may more completely address problem solution.

4. Selection of active intervention derives from understanding the client style and circumstance. Rollo May said, "Technique follows understanding." The unique interplay between elements in the client's circumstance and style forms the equasion for problem solution. What will work is an extension of what is present or what is critically absent in the interplay between circumstance and style. Once this is described, therapy proceeds into an active, dynamic, theory-based approach. At this juncture, clients may be enlisted in their own therapeutic process; therapists may become selectively directive, prescriptive, confrontational, active, interactive or whatever else is indicated by the described dynamics of circumstance and style and is within professional and ethical boundaries. The critical assessment of dynamics and the selection of the intervention having the highest probability of success enables the therapist to be forceful, systematic, accountable, and effective because therapy is proceeding toward a goal and in a theory-pure context.

There are, of course, client complexities that include the presence of problems from more than one category, and client styles that are mixed. There are conditions of internal incongruity and external ambiguity. Sometimes it is necessary to serialize therapy; i.e., resolve one problem with a theory-pure intervention before proceeding to a different problem and different intervention. It is possible to involve a colleague and engage in multiple therapies at the same time. The strength of the model is in isolating problem dynamics and client penchants so as to organize efficient interventions.

It is not suggested that a therapist be all things to all people. Rather it is proposed that the therapist be different things to different people; i.e., a behaviorist for a person with behavioral surpluses or deficits, a teacher to the ignorant, an anchor for the affectively detached, etc. Of great importance is that the therapist be what is needed at the time that and for the person for whom it is needed, that the intervention be pure. Like the unknown or counterproductive effects of mixed medications, mixed therapies hold high potential for neutralization or damage.

Professional accountability requires that therapists know what is effective and appropriate for what condition or circumstance of the particular client, and that they perform or facilitate its happening in assertive and efficient ways. Responsive Therapy provides a philosophy and a structure for enhancing such accountability.

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